MINUTES
MEETING OF INPATIENT PHYSICAL REHABILITATION SERVICES
TECHNICAL ADVISORY COMMITTEE
Of the Health Strategies Council
2 Peachtree Street, 34th Floor Conference Room, Atlanta, GA 30303

November 3, 2005
1:00 pm - 3:00 pm

Harve R. Bauguess, Chair, Presiding

MEMBERS PRESENT

Libba Bowling
Pamela Cartwright
James Courtney (for Carol Zafiratos)
Hazel Dorsey, RN, BSN, CCM
Patricia Fraley
John Lindsey
Dennis Skelley, FACHE
Mary Sloan, MPA
David Tatum (for Diane Waldner)
Wylene Watts
Dayna Whitley (via conference call)
Brian Williams
W. Gene Winters, CPA

MEMBERS ABSENT

Lillian Darden
Edwinlyn Heyward
Ron Hunt, MD
Kathy Kleinsteuber
Julia Mikell, MD
Gary Ulicny, PhD

GUESTS PRESENT

Jennifer Bach, Mitretek Healthcare
Armando Basarrate, Parker Hudson
Jeffrey Baxter, Nelson Mullins
Representative Bobby Franklin, House District 43
Lou Little, WellStar Health System
Helen Sloat, Nelson Mullins
Leah Watkins, Powell Goldstein

STAFF PRESENT

Charemon Grant, JD
Matthew Jarrard, MPA
Brigitte Maddox
Robert Rozier, JD
Rhathelia Stroud, JD
Stephanie Taylor, MPS

WELCOME AND INTRODUCTION OF NEW MEMBERS

Harve Bauguess called the meeting of the Inpatient Physical Rehabilitation Services Technical Advisory Committee (TAC) to order at 1:02 pm. He invited TAC members and guests to introduce themselves and formally welcomed three new TAC members namely, Lillian Darden, Brian Williams, and W. Gene Winters, CPA. He noted that Ms. Darden was unable to be present at today's meeting. Mr. Bauguess reminded members that new members were added based on the TAC's recommendation to secure additional expertise relating to long term acute care hospitals.

APPROVAL OF MINUTES

Mr. Bauguess asked for a motion to accept the minutes of the June 17th and July 29th meetings. A motion to accept the minutes of June 17th was made by Dennis Skelley, seconded by Patricia Fraley. The minutes were unanimously accepted. A motion to accept the minutes of the July 29th meeting was made by Pamela Cartwright, seconded by Hazel Dorsey. The minutes were unanimously accepted.

PUBLIC COMMENTS

Harve Bauguess provided an opportunity for the public to provide comments. No one requested to speak during the public comment portion of the meeting.

BRIEF OVERVIEW & DISTINCTION OF LTCH SERVICES

Harve Bauguess called on W. Gene Winters and Brian Williams to provide a brief overview of a long term care hospital (LTCH). Mr. Winters said that an LTCH is a long term care hospital that provides medical services to medically complex patients who require hospitalization, for a long period of time through a multidisciplinary, approach. Services are coordinated and integrated and include evaluation and treatment. LTCHs maintain an Average Length of Stay (ALOS) of 25-days among all of its patients (Medicare and other payors) in order for services to be reimbursed by Medicare. He further said that until the mid-1980's rehabilitation services that were provided to patients after acute care hospital stays

Following the overview, members made the following observations:

- Payment mechanisms (particularly, Medicare PPS/DRG) impacts admission process
- There is approximately 7% – 8% overlap in services between LTCHs and Rehab facilities
- Members suggested that CMS should adopt some facility-specific and patient specific admission criteria

CURRENT STATUS OF DRAFT RULES

Mr. Bauguess called on Robert Rozier to provide an update of the status of the Draft Proposed Rules (See Appendix A) Mr. Rozier said that the conceptually members have reviewed all of the proposed standards in the draft Rules and have reached consensus with regard to the standards contained in the draft rules. He said that the only area that needs additional work is the section on the need methodology. He said that the Department is awaiting guidance from the TAC with regard to the demand factors that should be used in the calculation of the need methodology.

UNRESOLVED ISSUES WITH PROPOSED DRAFT RULES

Mr. Rozier said that because members indicated that there is approximately a 7%-8% overlap between LTACHs and rehab facilities that the TAC needs to provide the Department with some guidance regarding how to account for this overlap in the development of the need methodology. Suggested that examine occupancy rates proposed by State of Maryland.

NEED METHODOLOGY
Members made the following observations:

- MEDPAC Study – is expected to establish some specific facility criteria. Study recommendations are expected to be released during January 2006;
- The TAC should be focused on how to determined an accurate need for beds around the state and how to account for those beds in all settings;
- TAC members agreed that there is no need for additional rehab beds around the state;.
- AMPRA Study – Department should examine this study to determine how to account for the demand factors in the draft need methodology. Dennis Skelley will forward this information to Matt Jarrard and/or Rob Rozier.
- Some flexibility should be added to

Department staff outlined some potential options that the committee could consider:

- Establish new demand factor
- Add a 7% - 8% factor
- Determine how other states, if any, address this issue and determine whether this option would work in Georgia (i.e. State of Maryland)

Following significant discussion in this area, committee members recommended that a 4% factor should be subtracted from both LTACH and rehab facilities to offset the overlap between these services. A motion to accept this recommendation was made by Dennis Skelley, seconded by Patricia Fraley. This motion was unanimously approved by the TAC.

PLANNING AREAS
The following data was requested by committee members:

- Overlay of all TBI programs on a map of the state (to determine the distance all programs are from each other (to consider whether all programs are at least 50 miles from each other)

MINIMUM BED SIZE
Members said that the minimum bed size relates to the integrity of the program. Members agreed that draft minimum bed sizes should remain as proposed:

CIPR (Adult) – 20 beds in freestanding facility (already offering CIPR)
- 20 beds in an acute care hospital
- 40 beds in freestanding facility (not already offering another CIPR program)

CIPR (Children) – 10 beds in freestanding rehab hospital (already offering CIPR)
- 10 beds in acute care hospital
- 40 beds in freestanding facility (not already offering another CIPR program)

TBI Program - 6 beds in a freestanding facility (already offering CIPR)
- 6 beds in acute care hospital
- 6 beds in a freestanding facility (not already offering CIPR)
- 6 beds in TBI facility

A TBI Program in a Life Long Living Program
-May not have more than 30 beds

A motion to accept these minimum bed size standards was made by Patricia Fraley, seconded by Pamela Cartwright. Committee members discussed the possibility of creating an exception to the need for providers in small counties. This discussion was tabled until the next meeting.

TAC members discussed how the beds at The Shepherd Center should be classified. Members suggested that one way to determine which category these beds should fall under would be to answer the question, "what is the hospital's business"? Members said that The Shepherd Center should not be listed in the inventory as both a rehab facility and an LTACH. Members agreed that further discussion should continue when Dr. Ulicny, President & CEO, The Shepherd Center and committee member is present at the meeting.

LTACH- DEFINITION

Robert Rozier reported that the Department developed a set of draft Rules for the development or expansion of LTACHs, (See Appendix B) noting that such applications would be reviewed under General Considerations unless and until the TAC created service-specific Rules. He noted that these rules were issued for public comment and are presently in effect. He said that there is still some question as to whether LTACHs should be considered general acute care hospitals. Members recommended that the definition of an LTACH should parallel that of CMS. Members said that this is a reimbursement driven classification more so than a different level of care. They agreed that the definition should indicate that for Medicare patients, the ALOS should be 25 days or greater. Members indicated that applications seeking to provide both "new" and "expanded" LTACH services must be classified by Medicare as an LTACH hospital.

Because of the overlap in the type of services that are offered to patients in rehab facilities and in LTACHs, members recommended that a subcommittee of the rehab TAC should be established to draft service-specific Rules for LTACHs. A subcommittee consisting of the following persons was named: W. Gene Winters, Brian Williams, Libba Bowling, Wylene Watts and Lillian Darden.

SERVICE-SPECIFIC NEED METHODOLOGY

Matt Jarrard described the current service-specific need methodology. He said that the committee needs to provide some guidance with regard to the demand factor prior to it being finalized.

NEXT MEETING

Members agreed that they would reconvene after the LTACH subcommittee has finished its work.

There being no further business, the committee adjourned at 2:55 pm. Minutes taken on behalf of Chair by Stephanie Taylor.

Respectfully Submitted

Harve Bauguess

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APPENDIX A

WORKING DRAFT PROPOSED RULES
OF
DEPARTMENT OF COMMUNITY HEALTH

111-2
HEALTH PLANNING

111-2-2
Certificate of Need

111-2-2-.35 Specific Review Considerations for Comprehensive Inpatient Physical Rehabilitation Services including Traumatic Brain injury

(1) **Applicability.**

(a) A Certificate of Need shall be required prior to the establishment of a new or the expansion of an existing Comprehensive Inpatient Physical Rehabilitation Adult Program. An application for Certificate of Need for a new or expanded Comprehensive Inpatient Physical Rehabilitation Adult Program shall be reviewed under the General Review Considerations of Rule 111-2-2-.09 and the service-specific review considerations of this Rule.

(b) A Certificate of Need shall be required prior to the establishment of a new or the expansion of an existing Comprehensive Inpatient Physical Rehabilitation Pediatric Program. An application for Certificate of Need for a new or expanded Comprehensive Inpatient Physical Rehabilitation Pediatric Program shall be reviewed under the General Review Considerations of Rule 111-2-2-.09 and the service-specific review considerations of this Rule.

(c) A Certificate of Need shall be required prior to the establishment of a new or the expansion of an existing Traumatic Brain Injury Transitional Living (All Ages) Program. An application for Certificate of Need for a new or expanded Traumatic Brain Injury Transitional Living (All Ages) Program shall be reviewed under the General Review Considerations of Rule 111-2-2-.09 and the service-specific review considerations of this Rule.

Should TBI Transitional Living and Life Long Living Program Require Separate CONs and Separate Need Methodologies?

(d) A Certificate of Need shall be required prior to the establishment of a new or the expansion of an existing Traumatic Brain Injury Life Long Living (All Ages) Program. An application for Certificate of Need for a new or expanded Traumatic Brain Injury Life Long Living (All Ages) Program shall be reviewed under the General Review Considerations of Rule 111-2-2-.09 and the service-specific review considerations of this Rule.

(2) **Definitions.**

New Definition of Adult: 18+
For Medical Necessity: 16+

(a) 'Adult' means persons eighteen years of age and over. However, a CON-authorized Comprehensive Inpatient Physical Rehabilitation Adult Program will not be in violation of the CON laws and regulations if it provides service to a patient older than fifteen years if the provider has determined that such service is

medically necessary, provided that the treatment days and patient census associated with patients sixteen and seventeen years of age do not exceed 10 percent of annual treatment days and annual census, respectively.

(b) 'Comprehensive Inpatient Physical Rehabilitation Program' means rehabilitation services provided to a patient who requires hospitalization, which provides coordinated and integrated services that include evaluation and treatment, and emphasizes education and training of those served. The program is applicable to those individuals who require an intensity of services which includes, as a minimum, physician coverage 24 hours per day, seven days per week, with daily (at least five days per week) medical supervision, complete medical support services including consultation, 24-hour-per-day nursing, and daily (at least five days per week) multidisciplinary rehabilitation programming for a minimum of three hours per day. Throughout this Rule, whenever this general term is used, it refers to the full spectrum of programs delineated in Rule 111-2-2-.35(1)(a) through (f).

New Definition of Expansion: Allows freestanding facilities to expand every two years without CON review if 85% Occupancy

(c) 'Expansion' and 'Expanded' mean the addition of beds to an existing CON-authorized Comprehensive Inpatient Physical Rehabilitation Program. However, a CON-authorized provider of Comprehensive Inpatient Physical Rehabilitation in a freestanding rehabilitation hospital or a traumatic brain injury facility may increase the bed capacity of an existing program by the lesser of ten percent of existing capacity or 10 beds if it has maintained an average occupancy of 85 percent for the previous twelve calendar months provided that there has been no such increase in the prior two years and provided that the capital expenditures associated with the increase do not exceed the capital expenditure threshold. If such an increase exceeds the capital expenditure threshold, the increase will be considered an expansion for which a Certificate of Need shall be required under these Rules.

(d) 'Freestanding Rehabilitation Hospital' means a specialized hospital organized and operated as a self-contained health care facility that provides one or more rehabilitation programs.

New Definition of New

(e) 'New' means a Program that has not provided Comprehensive Inpatient Physical Rehabilitation in the previous twelve months. Each of the programs described in 111-2-2-.35(1)(a) through (e) shall be considered independent programs such that a provider seeking to add a program not offered by that provider in the previous twelve months shall be considered to be offering a new program for which a Certificate of Need must be obtained.

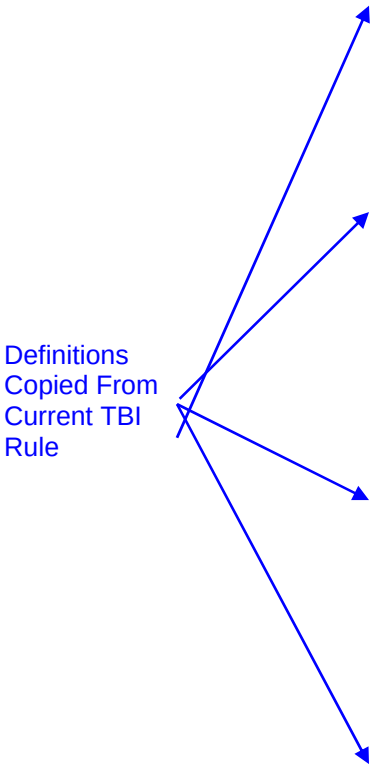
(f) 'Official State Health Component Plan' means the document related to Physical Rehabilitation Programs and Services developed by the Department, established by the Georgia Health Strategies Council and signed by the Governor of Georgia.

New Definition of Pediatric: 17- For Medical Necessity: 21-

(g) 'Pediatric' means persons seventeen years of age and under. However, a CON-authorized Comprehensive Inpatient Rehabilitation Pediatric Program will no be in violation of the CON laws and regulations if it provides service to a patient younger than twenty-two years if the provider has determined that such service is medically necessary, provided that the treatment days and patient census associated with patients eighteen, nineteen, twenty, and twenty-one years of age

do not exceed 10 percent of annual treatment days and annual census, respectively.

(h) 'Planning Area' means sub-state region for Physical Rehabilitation Programs and Services, as defined in the most recent official State Health Component Plan for Physical Rehabilitation Programs and Services.



(i) 'Traumatic Brain Injury' means a traumatic insult to the brain and its related parts resulting in organic damage thereto that may cause physical, intellectual, emotional, social, or vocational changes in a person. It shall also be recognized that a person having a traumatic brain injury may have organic damage or physical or social disorders, but shall not be considered mentally ill.

(j) 'Traumatic Brain Injury Facility' means a building which is devoted to the provision of residential treatment and rehabilitative care in a transitional living program or a life long living program for periods continuing for 24 hours or longer for persons who have traumatic brain injury. Such a facility is not classified by the Georgia Department of Human Resources or the Department of Community Health as a hospital, nursing home, intermediate care facility or personal care home.

(k) 'Traumatic Brain Injury Life Long Living (All Ages) Program' means such treatment and rehabilitative care as shall be delivered to traumatic brain injury clients who have been discharged from a more intense level of rehabilitation program, but who cannot live at home independently, and who require on-going lifetime support. Such clients are medically stable, may have special needs, but need less than 24 hour per day medical support.

(l) 'Traumatic Brain Injury Transitional Living (All Ages) Program' means such treatment and rehabilitative care as shall be delivered to traumatic brain injury clients who require education and training for independent living with a focus on compensation for skills which cannot be restored. Such care prepares clients for maximum independence, teaches necessary skills for community interaction, works with clients on pre-vocational and vocational training and stresses cognitive, speech, and behavioral therapies structured to the individual needs of clients. Such clients are medically stable, may have special needs, but need less than 24 hour per day medical support.

(3) **Service-Specific Review Standards.**

(a) The need for a new or expanded Comprehensive Inpatient Physical Rehabilitation Program shall be determined and applied as follows for the various types of Programs delineated in 111-2-2-.35(1):

1. The need for new or expanded Comprehensive Inpatient Physical Rehabilitation Adult Program in a planning area shall be determined using the following demand-based need projection:

(i) Determine the number of Adult cases statewide in each of the CIPR Diagnostic Categories that were reported in the most recent

complete year using the Georgia Discharge Data System or any data which is collected annually pursuant to O.C.G.A. 31-7-280(C);

(ii) Determine the Current Adult Utilization Rate by dividing the number of Adult discharges in each category by the concurrent year's Adult resident population.

Current Adult Utilization Rate = Current Adult Discharges / (Current Adult Resident Population / 1000)

(iii) Determine the Projected Adult Utilization Rate in the horizon year (five-years) by applying the Current Adult Utilization Rate to the horizon year's population.

Projected Adult Utilization Rate = (Projected Adult Resident Population / 1,000) X Current Adult Utilization Rate

(iv) Determine the number of projected adult admissions in the horizon year by applying the Projected Adult Utilization Rate against the Demand Factor percentage established for each category.

Projected Adult CIPR Admissions = Projected Adult Utilization Rate X Demand Factor Percentage

(v) Determine the Projected Adult Patient Days for CIPR in the horizon year for each category by applying the Projected Adult CIPR Admissions to the Expected Adult Average Length of Stay established for each category.

Projected Adult Patient Days = Projected Adult CIPR Admissions X Expected Adult Average Length of Stay

(vi) Add the Projected Adult Patient Days for each category to determine the Total Projected days for each CIPR Planning Area and then determine the number of beds needed if CIPR admissions utilized beds at 85% utilization.

Projected Gross Adult CIPR Beds = (Total Adult Projected Days/365) / 0.85

(vii) Determine the Net Projected Adult CIPR Beds needed in the horizon year by CIPR Planning Area by subtracting the Projected Gross Adult CIPR Beds from the Current Official Inventory of Existing and Approved Adult CIPR Beds for the Planning Area.

Net Projected Need/Surplus of Adult CIPR Beds = Existing and Approved Adult CIPR Beds - Projected Gross Adult CIPR Beds

2. The need for new or expanded Comprehensive Inpatient Physical Rehabilitation Pediatric Program in a planning area shall be determined using the following demand-based need projection:

(i) Determine the number of Pediatric cases statewide in each of the CIPR Diagnostic Categories that were reported in the most recent complete year using the Georgia Discharge Data System or any data which is collected annually pursuant to O.C.G.A. 31-7-280(C);

(ii) Determine the Current Pediatric Utilization Rate by dividing the number of Pediatric discharges in each category by the concurrent year's Pediatric resident population.

Current Pediatric Utilization Rate = Current Pediatric Discharges / (Current Pediatric Resident Population / 1000)

(iii) Determine the Projected Pediatric Utilization Rate in the horizon year (five-years) by applying the Current Pediatric Utilization Rate to the horizon year's population.

Projected Pediatric Utilization Rate = (Projected Pediatric Resident Population / 1,000) X Current Pediatric Utilization Rate

(iv) Determine the number of projected pediatric admissions in the horizon year by applying the Projected Pediatric Utilization Rate against the Demand Factor percentage established for each category.

Projected Pediatric CIPR Admissions = Projected Pediatric Utilization Rate X Demand Factor Percentage

(v) Determine the Projected Pediatric Patient Days for CIPR in the horizon year for each category by applying the Projected Pediatric CIPR Admissions to the Expected Pediatric Average Length of Stay established for each category.

Projected Pediatric Patient Days = Projected Pediatric CIPR Admissions X Expected Pediatric Average Length of Stay

(vi) Add the Projected Pediatric Patient Days for each category to determine the Total Projected days for each CIPR Planning Area and then determine the number of beds needed if CIPR admissions utilized beds at 85% utilization.

Projected Gross Pediatric CIPR Beds = (Total Pediatric Projected Days/365) / 0.85

(vii) Determine the Net Projected Pediatric CIPR Beds needed in the horizon year by CIPR Planning Area by subtracting the Projected Gross Pediatric CIPR Beds from the Current Official Inventory of Existing and Approved Pediatric CIPR Beds for the Planning Area.

Net Projected Need/Surplus of Pediatric CIPR Beds = Existing and Approved Pediatric CIPR Beds - Projected Gross Pediatric CIPR Beds

3. The need for new or expanded Traumatic Brain Injury Life Long Living (All Ages) Program in a planning area shall be determined [Methodology TO BE Described]

4. The need for new or expanded Traumatic Brain Injury Transitional Living (All Ages) Program in a planning area shall be determined [Methodology TO BE Described]

Adverse Impact Standard: Will Cause a Facility to Drop 10% Utilization

(b) An applicant for a new or expanded Comprehensive Inpatient Physical Rehabilitation Program shall document that the establishment or expansion of its program will not have an adverse impact on existing and approved programs of the same type in its planning area. An applicant for a new or expanded Comprehensive Inpatient Physical Rehabilitation Program shall have an adverse impact on existing and approved programs of the same type if it will decrease annual utilization by ten percent by the horizon year. The applicant shall provide evidence of projected impact by taking into account existing planning area market share of programs of the same type and future population growth.

Exception to Need and Adverse Impact: Only for Adult Programs? To Be Discussed

(c) The Department may grant an exception to the need methodology of 111-2-2-.35(3)(a)1 and to the adverse impact standard of 111-2-2-.35(3)(b) for an applicant proposing a program to be located in a county with a population of less than 40,000 and to be located a minimum of 50 miles away from any existing program in the state; or to remedy an atypical barrier to Comprehensive Inpatient Physical Rehabilitation Programs based on cost, quality, financial access or geographic accessibility; or if the applicant's annual census demonstrates 30 percent out of state utilization for the previous two years.

(d) A new Comprehensive Inpatient Physical Rehabilitation Program shall have the following minimum bed sizes based on type of Program offered:

Minimum Bed Sizes for New Programs: To be Discussed and Verified

1. A new Comprehensive Inpatient Physical Rehabilitation Adult Program shall have a minimum bed size of 20 beds in a freestanding rehabilitation hospital already offering another Comprehensive Inpatient Physical Rehabilitation Program, 20 beds in an acute-care hospital, and 40 beds for a new freestanding rehabilitation hospital not already offering another Comprehensive Inpatient Physical Rehabilitation Program.

2. A new Comprehensive Inpatient Physical Rehabilitation Pediatric Program shall have a minimum of 10 beds in a freestanding rehabilitation hospital already offering another Comprehensive Inpatient Physical Rehabilitation Program, 10 beds in an acute-care hospital, and 40 beds for a new freestanding rehabilitation hospital not already offering another Comprehensive Inpatient Physical Rehabilitation Program.

3. A new Traumatic Brain Injury Transitional Living Program shall have a minimum of 6 beds in a freestanding rehabilitation hospital already offering another Comprehensive Inpatient Physical Rehabilitation Program, 6 beds in an acute-care hospital, 6 beds for a new freestanding rehabilitation hospital not already offering another Comprehensive Inpatient Physical Rehabilitation Program, and 6 beds in a Traumatic Brain Injury Facility. A Traumatic Brain Injury Life Long Living Program may not have more than 30 beds unless the applicant provides documentation satisfactory to the Department that the program design, including staffing patterns and the physical plant, are such as to promote services which are of high quality, are cost-effective and are consistent with client needs.

4. A new Traumatic Brain Injury Life Long Living Program shall have a minimum of 6 beds in a freestanding rehabilitation hospital already offering another Comprehensive Inpatient Physical Rehabilitation Program, 6 beds in an acute-care hospital, 6 beds for a new freestanding rehabilitation hospital not already offering another Comprehensive Inpatient Physical Rehabilitation Program, and 6 beds in a Traumatic Brain Injury Facility. A Traumatic Brain Injury Life Long Living Program may not have more than 30 beds unless the applicant provides documentation satisfactory to the Department that the program design, including staffing patterns and the physical plant, are such as to promote services which are of high quality, are cost-effective and are consistent with client needs.

(e) An applicant for a new Comprehensive Inpatient Physical Rehabilitation Program shall demonstrate the intent to meet the standards of the Commission on Accreditation of Rehabilitation Facilities ("CARF") applicable to the type of Program to be offered within 18 months of offering the new service.

(f) An applicant for an expanded Comprehensive Inpatient Physical Rehabilitation Program shall be accredited by the Commission on Accreditation of Rehabilitation Facilities ("CARF") for the type of Program which the applicant seeks to expand prior to application. The applicant must provide proof of such accreditation.

(g) An applicant for a new freestanding rehabilitation hospital shall demonstrate the intent to meet the licensure Rules of the Georgia Department of Human Resources for such hospitals.

(h) An applicant for an expanded freestanding rehabilitation hospital shall demonstrate a lack of uncorrected deficiencies as documented by letter from the Georgia Department of Human Resources.

TBI Licensure Standards

(i) An applicant for a new Traumatic Brain Injury Transitional Living (All Ages) Program and/or a new Traumatic Brain Injury Life Long Living (All Ages) Program in a Traumatic Brain Injury Facility shall demonstrate the intent to meet the licensure Rules of the Georgia Department of Human Resources for Traumatic Brain Injury Facilities (Chapter 290-5-53). An applicant for an expanded Traumatic Brain Injury Transitional Living (All Ages) Program and/or an expanded Traumatic Brain Injury Life Long Living (All Ages) Program in a Traumatic Brain Injury Facility shall demonstrate a lack of uncorrected deficiencies as documented by letter from the Georgia Department of Human Resources.

(j) An applicant for a new or expanded Comprehensive Inpatient Physical Rehabilitation Program shall have written policies and procedures for utilization review. Such review shall consider, but is not limited to, factors such as medical necessity, appropriateness and efficiency of services, quality of patient care, and rates of utilization.

(k) An applicant for a new or expanded Comprehensive Inpatient Physical Rehabilitation Program in a Freestanding Rehabilitation Hospital or Traumatic Brain Injury Facility shall document the existence of referral arrangements with an acute-care hospital(s) within the planning area to provide acute and emergency medical treatment to any patient who requires such care.

(l) An applicant for a new or expanded Comprehensive Inpatient Physical Rehabilitation Program shall foster an environment that assures access to services to individuals unable to pay and regardless of payment source or circumstances by the following:

1. providing evidence of written administrative policies and directives related to the provision of services on a nondiscriminatory basis;

2. providing a written commitment that un-reimbursed services for indigent and charity patients in the service will be offered at a standard which meets or exceeds three percent of annual gross revenues for the service after Medicare and Medicaid contractual adjustments and bad debt have been deducted;

3. providing documentation of the demonstrated performance of the applicant, and any facility in Georgia owned or operated by the applicant's parent organization, of providing services to individuals unable to pay based on the past record of service to Medicare, Medicaid, and indigent and charity patients, including the level of un-reimbursed indigent and charity care; and

4. providing documentation of current or proposed charges and policies, if any, regarding the amount or percentage of charges that charity patients, self pay patients, and the uninsured will be expected to pay.

Additional Financial Accessibility Standards

A provider offering more than one program in Comprehensive Inpatient Physical Rehabilitation may make one written commitment for the entire service as opposed to several commitments for the various programs within the service; however, an acute care hospital may not substitute an institution-wide commitment in lieu of this service-specific commitment.

m. In addition to the requirements of 111-2-2-.35(3)(l) an applicant for an expanded Comprehensive Inpatient Physical Rehabilitation Program shall be meeting or exceeding any and all previous commitments to indigent and charity care. If the applicant has not provided the level of indigent and charity care services sufficient to meet such commitments, the applicant may satisfy this requirement by paying a fine equal to the difference in the amount of services provided and the commitment made.

n. An applicant for a new or expanded Comprehensive Inpatient Physical Rehabilitation Program shall agree to provide the Department with requested information and statistical data related to the operation of such a Program on a yearly basis, or as needed, and in a format requested by the Department.

(4) EXCEPTIONS.

a. Rehabilitation programs specifically focused towards treatment of spinal cord injuries and disorders and which existed prior to the effective date of this version of Rule 111-2-2-.35 shall not be subject to the age limitations imposed by Rule 111-2-2-.35(2)(a) and (g). Such programs may treat any patient aged twelve and over.

b. Traumatic Brain Injury programs and facilities which existed prior to the effective date of this version of Rule 111-2-2-.35 shall not be subject to the age limitations imposed by Rule 111-2-2-.35(2)(a) and (g). Such programs may treat any patient regardless of age.

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APPENDIX B

RULES
OF
GEORGIA DEPARTMENT OF COMMUNITY HEALTH

CHAPTER 111-2
HEALTH PLANNING

SUB-CHAPTER 111-2-2
Certificate of Need

111-2-2-.36 Specific Review Considerations for Long Term Care Hospitals.

(1) Applicability. A certificate of need will be required prior to the establishment of any new long term care hospital; the expansion of any existing long term care hospital; or the consolidation of long term care hospitals. Any such establishment, expansion, or consolidation shall be reviewed solely under the general considerations of 111-2-2-.09.

(2) Definitions.

(a) "Consolidation" means the merger of two or more existing long term care hospitals into a single facility without exceeding the combined bed capacity of the existing hospitals;

(b) "Expansion" means the addition of beds, regardless of cost, or the expenditure of funds in excess of the current capital expenditure threshold;

(c) "Long term care hospital" means a freestanding hospital or a hospital located within a general acute care hospital, which, in the case of an existing facility, has an average length of stay of greater than 25 days and is certified by the Center for Medicare and Medicaid Services ("CMS") as a long term care hospital, or, which, in the case of an applicant proposing to establish a long term care hospital, proposes to have an average length of stay of greater than 25 days and proposes to be certified by CMS as a long term care hospital.

AUTHORITY: O.C.G.A. §§ 31-5A *et seq.* and 31-6 *et seq.*